		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045203

Facility Name: GROSS POINTE MANOR

Address: 6601 WEST TOUHY AVENUE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-4411703001

Date of Initial License for Current Owners: 09/07/01

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code ____		[ ]	Corporation	[ ]	Other ____
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other ____		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERRY MAUER
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,964	1,964	8
9	SNF/PED					9
10	ICF	23,657	5,953		29,610	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,657	5,953	1,964	31,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.38%

D. How many bed-hold days during this year were paid by Public Aid?
65 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 47 and days of care provided 1,850

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	233,999	21,234	5,540	260,773		260,773		260,773			1
2	Food Purchase		202,414		202,414	(17,703)	184,711	(2,055)	182,656			2
3	Housekeeping	56,312	20,234		76,546		76,546		76,546			3
4	Laundry	53,910	6,048	1,675	61,633		61,633		61,633			4
5	Heat and Other Utilities			112,180	112,180		112,180	791	112,971			5
6	Maintenance	60,281	37,723	16,160	114,164		114,164	630	114,794			6
7	Other (specify):*			8,131	8,131		8,131		8,131			7
8	**TOTAL General Services**	404,502	287,653	143,686	835,841	(17,703)	818,138	(634)	817,504			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	1,311,099	67,595	28,359	1,407,053		1,407,053	(270)	1,406,783			10
10a	Therapy			1,579	1,579		1,579		1,579			10a
11	Activities	113,230	4,943	1,786	119,959		119,959		119,959			11
12	Social Services	32,706		1,103	33,809		33,809		33,809			12
13	Nurse Aide Training			900	900		900		900			13
14	Program Transportation			508	508		508		508			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,457,035	72,538	38,735	1,568,308		1,568,308	(270)	1,568,038			16
	C. General Administration											
17	Administrative	81,160			81,160		81,160	45,723	126,883			17
18	Directors Fees											18
19	Professional Services			44,978	44,978		44,978	2,152	47,130			19
20	Dues, Fees, Subscriptions & Promotions			42,359	42,359		42,359	(37,618)	4,741			20
21	Clerical & General Office Expenses	150,585	13,324	75,498	239,407		239,407	(100,742)	138,665			21
22	Employee Benefits & Payroll Taxes			378,766	378,766	17,703	396,469		396,469			22
23	Inservice Training & Education			370	370		370		370			23
24	Travel and Seminar							435	435			24
25	Other Admin. Staff Transportation			577	577		577		577			25
26	Insurance-Prop.Liab.Malpractice			88,451	88,451		88,451	2,373	90,824			26
27	Other (specify):*							8,861	8,861			27
28	**TOTAL General Administration**	231,745	13,324	630,999	876,068	17,703	893,771	(78,816)	814,955			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,093,282	373,515	813,420	3,280,217		3,280,217	(79,720)	3,200,497			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: GROSS POINTE MANOR **#0045203** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,043	
	REPAIRS & MAINTENANCE		1,497	
			0	5,540
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,675	
			0	1,675
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		40,054	
	ELECTRICITY		54,026	
	WATER		16,429	
	CABLE TV - LOBBY		1,671	
			0	112,180
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,621	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,322	
	ELEVATOR MAINTENANCE & REPAIR		5,737	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,480	
	FIRE SERVICE		0	
			0	
			0	
			0	16,160
7	**OTHER**			
	SCAVENGER		8,131	
	SECURITY SERVICE		0	8,131
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,500	4,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	25,650	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,089	
	PHARMACY CONSULTANT	XVIII B 39-2	1,620	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	28,359
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	647	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	908	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	24	1,579
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,786	
			0	1,786
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,103	
			0	1,103
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	900	900

Facility Name & ID Number GROSS POINTE MANOR **#0045203** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		508	508
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,953	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	41,025	
			0	44,978
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	38,217	
	EMPLOYEE WANT ADS	XIX F	836	
	CONTRIBUTIONS	VI 20 XIX F	118	
	DUES & SUBSCRIPTIONS	XIX F	90	
	LICENSES & PERMITS	XIX F	3,098	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	42,359
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		1,372	
	OUTSIDE CLERICAL SERVICES		48,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	9,327	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,799	
	MESSENGER SERVICE		0	
			0	75,498

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	158,210	
	UNEMPLOYMENT COMPENSATION	XIX D	42,035	
	WORKERS COMPENSATION INSURANCI	XIX D	45,748	
	HOSPITALIZATION INSURANCE	XIX D	119,868	
	EMPLOYEE BENEFITS - OTHER	XIX D	12,905	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	378,766
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		370	370
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		577	577
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		88,451	88,451
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 813,420

Facility Name & ID Number GROSS POINTE MANOR #0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			19,282	19,282		19,282	125,741	145,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,139	57,139		57,139	250,497	307,636			32
33	Real Estate Taxes			108,501	108,501		108,501	1,919	110,420			33
34	Rent-Facility & Grounds			306,000	306,000		306,000	(306,000)				34
35	Rent-Equipment & Vehicles			14,243	14,243		14,243	5,285	19,528			35
36	Other (specify):*											36
37	**TOTAL Ownership**			505,165	505,165		505,165	77,442	582,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,876	50,475	123,351		123,351	(578)	122,773			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		72,876	104,678	177,554		177,554	(578)	176,976			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,093,282	446,391	1,423,263	3,962,936		3,962,936	(2,856)	3,960,080			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(84,577)	30		9
10	Interest and Other Investment Income	(119)	32		10
11	Discounts, Allowances, Rebates & Refunds	(799)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,256)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(9,327)	21		18
19	Entertainment		20		19
20	Contributions	(118)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(38,217)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(77,066)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (211,479)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	208,623		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 208,623		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,856)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS Page 5A

GROSS POINTE MANOR

ID# 0045203

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	MARKETING SALARY	(77,066)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(77,066)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,055)	0	0	0	0	0	0	0	0	0	0	(2,055)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	791	0	0	0	0	0	0	0	0	791	5
6	Maintenance	0	0	630	0	0	0	0	0	0	0	0	630	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,055)	0	1,421	0	0	0	0	0	0	0	0	(634)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(270)	0	0	0	0	0	(270)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(270)	0	0	0	0	0	(270)	16
	C. General Administration													
17	Administrative	0	0	0	45,723	0	0	0	0	0	0	0	45,723	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	2,152	0	0	0	0	0	0	0	0	2,152	19
20	Fees, Subscriptions & Promotions	(38,335)	0	717	0	0	0	0	0	0	0	0	(37,618)	20
21	Clerical & General Office Expenses	(86,393)	(48,000)	28,920	4,731	0	0	0	0	0	0	0	(100,742)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	435	0	0	0	0	0	0	0	0	435	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,373	0	0	0	0	0	0	0	0	2,373	26
27	Other (specify):*	0	0	4,944	0	3,917	0	0	0	0	0	0	8,861	27
28	**TOTAL General Administration**	(124,728)	(48,000)	39,541	50,454	3,917	0	0	0	0	0	0	(78,816)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(126,783)	(48,000)	40,962	50,454	3,917	(270)	0	0	0	0	0	(79,720)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GROSS POINTE MANOR # 0045203 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(84,577)	207,644	2,674	0	0	0	0	0	0	0	0	125,741	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(119)	248,085	2,531	0	0	0	0	0	0	0	0	250,497	32
33	Real Estate Taxes	0	0	1,919	0	0	0	0	0	0	0	0	1,919	33
34	Rent-Facility & Grounds	0	(306,000)	0	0	0	0	0	0	0	0	0	(306,000)	34
35	Rent-Equipment & Vehicles	0	0	5,285	0	0	0	0	0	0	0	0	5,285	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(84,696)	149,729	12,409	0	0	0	0	0	0	0	0	77,442	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(578)	0	0	0	0	0	(578)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(578)	0	0	0	0	0	(578)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(211,479)	101,729	53,371	50,454	3,917	(848)	0	0	0	0	0	(2,856)	45

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING SERVICES	$ 48,000	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (48,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	306,000	GROSS POINT MANOR REALTY LLC			(306,000)	7
8	V	30	DEPRECIATION		" "		207,644	207,644	8
9	V	32	INTEREST		" "		248,085	248,085	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 354,000			$ 455,729	$ * 101,729	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 791	$ 791	15
16	V	6	REPAIR & MAINT.		" " "		630	630	16
17	V	7	EMP. BEN. - GEN, SERVICES		" " "				17
18	V	19	PROFESSIONAL FEES		" " "		2,152	2,152	18
19	V	20	DUES AND SUBSCRIPTION		" " "		717	717	19
20	V	21	CLERICAL & GENERAL		" " "		28,920	28,920	20
21	V	24	SEMINARS AND TRAVEL		" " "		435	435	21
22	V	26	INSURANCE		" " "		2,373	2,373	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "		4,944	4,944	23
24	V	30	DEPRECIATION		" " "		2,674	2,674	24
25	V	32	INTEREST		" " "		2,531	2,531	25
26	V	33	REAL ESTATE TAXES		" " "		1,919	1,919	26
27	V	35	EQUIPMENT RENTAL		" " "		5,285	5,285	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 53,371	$ * 53,371	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$	15
16	V	10	NURSING CMP. - SUE G.		" " "				16
17	V	17	ADMIN. CMP. - M. MAUER		" " "		28,209	28,209	17
18	V	17	ADMIN. CMP. - M. AARON		" " "				18
19	V	17	ADMIN. CMP. - F. AARON		" " "				19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "				20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "				21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "		7,792	7,792	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "				23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "				24
25	V	17	ADMIN. CMP. - S. LEVY		" " "		9,722	9,722	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		" " "				26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "				27
28	V	21	CLERICAL. CMP. - S. AARON		" " "		4,731	4,731	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 50,454	$ * 50,454	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$	15
16	V	15	EMP. BEN. - SUE G.		" " "				16
17	V	27	EMP.BEN. - M. MAUER		" " "		895	895	17
18	V	27	EMP. BEN. - M. AARON		" " "				18
19	V	27	EMP. BEN. - F. AARON		" " "				19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "				20
21	V	27	EMP. BEN. - S. KOPLIN		" " "				21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "		684	684	22
23	V	27	EMP. BEN. - E. CASSON		" " "				23
24	V	27	EMP. BEN. - S. BOGEN		" " "				24
25	V	27	EMP. BEN. - S. LEVY		" " "		1,406	1,406	25
26	V	27	EMP. BEN. - H. ALTER		" " "				26
27	V	27	EMP. BEN. - NON-OWNER		" " "				27
28	V	27	EMP. BEN. - S. AARON		" " "		932	932	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 3,917	$ * 3,917	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC REHAB CONSULTANTS LLC		$	$	15
16	V	19	PROFESSIONAL FEES		" " "				16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	1,071	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	801	(270)	21
22	V	39	ANCILLARY EXPENSE	2,288	" " "		1,710	(578)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,359			$ 2,511	$ * (848)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	SHERRY MAUER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 81,160	17-1	1
2	SHERRY MAUER		NURSING						14,280	10-1	2
3	MARSHALL MAUER		ADMINISTRATIVE						28,209	17-7	3
4	SHARON AARON		CLERICAL						4,731	21-7	4
5	DOVIE MAUER		FILE CLERK						28,290	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 156,670		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	423,801	12	$ 10,611	$	31,574	$ 791	1
2	6	REPAIR & MAINT.	" "	423,801	12	8,462		31,574	630	2
3	7	EMP. BEN. - GEN, SERVICES	" "	423,801	12			31,574	0	3
4	19	PROFESSIONAL FEES	" "	423,801	12	28,879		31,574	2,152	4
5	20	DUES AND SUBSCRIPTION	" "	423,801	12	9,628		31,574	717	5
6	21	CLERICAL & GENERAL	" "	423,801	12	388,179	279,093	31,574	28,920	6
7	24	SEMINARS AND TRAVEL	" "	423,801	12	5,844		31,574	435	7
8	26	INSURANCE	" "	423,801	12	31,856		31,574	2,373	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	423,801	12	66,362		31,574	4,944	9
10	30	DEPRECIATION	" "	423,801	12	35,898		31,574	2,674	10
11	32	INTEREST	" "	423,801	12	33,975		31,574	2,531	11
12	33	REAL ESTATE TAXES	" "	423,801	12	25,761		31,574	1,919	12
13	35	EQUIPMENT RENTAL	" "	423,801	12	70,935		31,574	5,285	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 716,390	$ 279,093		$ 53,371	25

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
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City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 59,901	$ 59,901		$	1
2	10	NURSING CMP. - SUE G.	" "							2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	373,726	373,726	3	28,209	3
4	17	ADMIN. CMP. - M. AARON	" "	40	9	490,141	490,141			4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,118	191,118			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	40	3	49,500	49,500			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	7	69,097	69,097			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	77,417	77,417	5	7,792	8
9	17	ADMIN. CMP. - E. CASSON	" "							9
10	17	ADMIN. CMP. - S. BOGEN	" "	11	2	40,545	40,545			10
11	17	ADMIN. CMP. - S. LEVY	" "	45	11	128,818	128,818	3	9,722	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	11	153,375	153,375			13
14	21	CLERICAL CMP. - S. AARON	" "	40	11	62,676	62,676	3	4,731	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,708,314	$ 1,708,314		$ 50,454	25

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847)679-8219
Fax Number: (847)679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 5,106	$		$	1
2	15	EMP. BEN. - SUE G.	" "							2
3	27	EMP.BEN. - M. MAUER	" "	40	11	11,858		3	895	3
4	27	EMP. BEN. - M. AARON	" "	40	9	16,312				4
5	27	EMP. BEN. - F. AARON	" "	45	6	32,071				5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	40	3	26,160				6
7	27	EMP. BEN. - S. KOPLIN	" "	40	7	26,142				7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	9	6,801		5	684	8
9	27	EMP. BEN. - E. CASSON	" "							9
10	27	EMP. BEN. - S. BOGEN	" "	11	2	3,320				10
11	27	EMP. BEN. - S. LEVY	" "	45	11	18,630		3	1,406	11
12	27	EMP. BEN. - H. ALTER	" "	40	1	4,292				12
13	27	EMP. BEN. - NON-OWNER	" "	45	11	23,348				13
14	27	EMP. BEN. - S. AARON	" "	40	11	12,346		3	932	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 186,386	$		$ 3,917	25

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Dynamic Healthcare Consultants
Street Address: 3359 W. Main St.
City / State / Zip Code: Skokie, IL 60076
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						801	9
10	39	ANCILLARY EXPENSE	" "						1,710	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,511	25

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MB FINANCIAL		X	MORTGAGE			$	$ 4,826,585			$ 248,085	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				1,025,000			48,442	6
7			X	INSURANCE FINANCING							2,578	7
8	RELATED PARTY	X		LINE OF CREDIT				175,275			6,119	8
9	TOTAL Facility Related						$	$ 6,026,860			$ 305,224	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 6,026,860			$ 305,224	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 105,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 105,501	2
3. Under or (over) accrual (line 2 minus line 1).		$ 501	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 108,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 108,501	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002	105,501	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROSS POINTE MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045203

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31-205-031-0000	NURSING HOME	$ 72,714.85	$ 72,714.85
2.	10-31-205-030-0000	NURSING HOME	$ 32,786.31	$ 32,786.31
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 105,501.16	$ 105,501.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2001	$ 573,648	1
2					2
3	TOTALS			$ 573,648	3

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2001		$ 3,862,200	$ 207,644	27.5	$ 134,598	$ (73,046)	$ 403,794	4
5											5
6											6
7											7
8					33,049	847		944	97	9,757	8
	Improvement Type**										
9	ICE MACHINE DRAIN/COOLING PUMP/WATER PUMP			2001	6,224	226	27.5	226			9
10	ROOFING			2001	34,800	1,265	27.5	1,265			10
11	SURVEILLANCE EQUIP/ANTENNA			2001	2,250	82	27.5	82			11
12	TELEPHONE/SPLITTERS			2001	609	7	7	7			12
13	DINING CAR/ROOM SIGNS			2001	8,744	312	27.5	312			13
14	MONITOR / CAMERA			2002	5,303	196	27.5	196			14
15	MEZUZAHS			2002	2,240	83	27.5	83			15
16	WIRING / WATER VALVE / PUMP / VENTILATOR			2002	7,756	277	27.5	277			16
17	COMPRESSOR			2003	1,364	23	27.5	23			17
18	SATELLITE DISH SYSTEM			2003	1,054	18	27.5	18	(0)		18
19	WALK IN COOLER			2003	3,920	65	27.5	65			19
20	DRAIN			2003	923	15	27.5	15			20
21	SMOKE DETECTORS			2003	1,761	29	27.5	29			21
22	VIDEO CAMERA			2003	896	15	27.5	15			22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,973,093	$ 211,104		$ 138,155	$ (72,949)	$ 413,551	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 31,298	$ 6,446	$ 3,129	$ (3,317)	10	$ 7,703	71
72	Current Year Purchases	18,906	10,223	945	(9,278)	10	945	72
73	Fully Depreciated Assets							73
74	Related Party	20,276	1,117	1,593	476	10	13,818	74
75	TOTALS	$ 70,480	$ 17,786	$ 5,667	$ (12,119)		$ 22,466	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party			$ 4,194	$ 710	$ 1,201	$ 491		$ 4,111	76
77										77
78										78
79										79
80	TOTALS			$ 4,194	$ 710	$ 1,201	$ 491		$ 4,111	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,621,415	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,600	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 145,023	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (84,577)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 440,128	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,599 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ 480.00	$ 2,400	17
18			463.00	3,244	18
19					19
20					20
21	TOTAL		$ 943.00	$ 5,644	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
COMMUNITY COLLEGE	[ ]
HOURS PER AIDE	

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
HOURS PER AIDE	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 900
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$ 900
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GROSS POINTE MANOR

STATE OF ILLINOIS
0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 17,939	$		$ 17,939	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			798			798	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			31,738			31,738	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				60,493		60,493	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,LAB,RADIOLOGY Other (specify):	39-2					12,383		12,383	13
14	TOTAL			$		$ 50,475	$ 72,876		$ 123,351	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	596,775		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,953		6
7	Other Prepaid Expenses	3,906		7
8	Accounts Receivable (owners or related parties)	50,873		8
9	Other(specify): RE TAX ESCROW	27,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 703,507	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	77,844		15
16	Equipment, at Historical Cost	50,203		16
17	Accumulated Depreciation (book methods)	(37,090)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	900		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 91,857	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 795,364	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 373,062	$	26
27	Officer's Accounts Payable	175,275		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,025,000		29
30	Accrued Salaries Payable	164,483		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,121		31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,000		32
33	Accrued Interest Payable	1,428		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,859,369	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,859,369	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,064,005)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 795,364	$	48

*(See instructions.)

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,217,043)	1
2	Restatements (describe):		2
3		(5,353)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,222,396)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	158,391	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 158,391	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,064,005)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,051,926	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,051,926	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,177	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 68,177	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	119	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 119	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	799	28
28a	VENDING - NET OF COST	306	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,105	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,121,327	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	835,841	31
32	Health Care	1,568,308	32
33	General Administration	876,068	33
	B. Capital Expense		
34	Ownership	505,165	34
	C. Ancillary Expense		
35	Special Cost Centers	123,351	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,962,936	40
41	**Income before Income Taxes (line 30 minus line 40)****	158,391	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 158,391	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,135	2,281	$ 66,193	$ 29.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,074	7,765	200,542	25.83	3
4	Licensed Practical Nurses	12,422	13,511	317,305	23.48	4
5	Nurse Aides & Orderlies	59,835	63,589	727,059	11.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,815	1,992	26,813	13.46	9
10	Activity Assistants	6,328	6,865	86,417	12.59	10
11	Social Service Workers					11
12	Dietician	2,229	2,362	33,383	14.13	12
13	Food Service Supervisor					13
14	Head Cook	3,717	4,237	54,031	12.75	14
15	Cook Helpers/Assistants	10,617	11,457	98,963	8.64	15
16	Dishwashers	5,883	6,170	47,622	7.72	16
17	Maintenance Workers	4,307	4,559	60,281	13.22	17
18	Housekeepers	6,182	6,619	56,312	8.51	18
19	Laundry	5,302	5,964	53,910	9.04	19
20	Administrator	2,086	2,319	81,160	35.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,571	8,067	150,585	18.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) PLCMT COORD	2,013	2,066	32,706	15.83	33
34	TOTAL (lines 1 - 33)	139,516	149,823	$ 2,093,282 *	$ 13.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	101	$ 4,043	1-3	35
36	Medical Director	90	4,500	9-3	36
37	Medical Records Consultant	17	1,089	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	40	1,620	10-3	39
40	Physical Therapy Consultant	13	647	10a-3	40
41	Occupational Therapy Consultant	19	908	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		24	10a-3	43
44	Activity Consultant	38	1,786	11-3	44
45	Social Service Consultant	24	1,103	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	342	$ 15,720		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	339	15,719	10-3	51
52	Nurse Aides	335	9,931	10-3	52
53	TOTAL (lines 50 - 52)	673	$ 25,650		53

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHERRY MAUER	ADMIN		$ 81,160
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,160

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR	ACCOUNTING	$ 16,590
FROST RUTTENBERG	ACCOUNTING	4,160
KATZ RANDALL	LEGAL	1,100
WINSTON & STRAWN	LEGAL	2,770
SACHNOFF WEAVER	LEGAL	216
FINKEL MARTWICK	LEGAL	1,227
HEALTH DATA SYSTEM	DATA PROCESSING	3,953
		14,962
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 44,978

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 45,748
Unemployment Compensation Insurance		42,035
FICA Taxes		158,210
Employee Health Insurance		119,868
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		12,905
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,111
Advertising: Employee Recruitment	836
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	38,217
TRUST/FRANCHISE/CONTRIB/ETC	118
LICENSES & PERMITS	987
DUES & SUBSCRIPTIONS	90
MGMT CO ALLOCATION	717
TRUST/FRANCHISE/CONTRIB/ETC	(118)
Less: Public Relations Expense	(0)
Non-allowable advertising	(38,217)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,741

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	435
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 435

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GROSS POINTE MANOR # 0045203 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 32,611 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 54,203
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ #REF! Has any meal income been offset against related costs? NO Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees